Panel Discussion on Malaria
Session One

Participants:
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Minister Aguinaldo Jaime
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DR. HILL: Ladies and gentlemen, I want to welcome you to this special malaria event today. And it has been planned for some time. It is an exciting morning for us.

We are just delighted that you are here, and we are delighted that we have the kind of guests that we have present for the two panels, and our special session with, of course, the First Lady.

As many of you know, malaria itself is the number one killer of children in Africa, causing the death of at least one million infants and children under the age of five every year. That's a million children who will never have the chance to lead productive lives.

Both in absolute terms and relative terms, to much of the rest of the world, Africa is carrying a greater disease burden than it was two decades ago. Only in the past few years have we seen any clear indication that we might be turning the corner, and making progress at least in some areas.

Beginning in about 2000, three new highly efficacious tools became available through USAID and other donor research – through donor research, etc., to try to address the question of malaria.

Combined and fielded together, these measures represent the first truly comprehensive and globally supported anti-malaria strategy to be deployed, in the one place that needs it most.

The first new tool is insecticide treated nets – ITNs, as they are called – as a vehicle to get insecticides inside people's homes.

Second is the intermittent preventative therapy – IPT – of pregnant women. This is the treatment critical because the child's vulnerability begins even before birth.

And third, of course, are artemisinin-based combination therapies – ACTs, as they are called. These are new combination drugs derived from a very old, natural Chinese anti-malarial medicine. ACTs' effectiveness provides a remarkable opportunity to plug the hole left by the treatment failures of older therapies. And USAID is vigorously supporting their development and availability.

The spraying of homes, called indoor residual spraying, is a proven effective tool worldwide that we are looking to apply throughout Africa. DDT is one of 12 insecticides that can be used for IRS. DDT is normally considered to have

an advantage on rough wall surfaces, such as mud or unplastered cinderblock. In most situations, it has also a longer lasting insecticidal effect, which is generally considered to last more than six months, but has been documented in some cases to last 12 months in South Africa.

DDT projects funded by USAID are expected to begin this year in Ethiopia, Zambia and Mozambique.

The PMI, the President's Malaria Initiative, is supporting and rolling out cost effective tools that are delivering results. The PMI is also moving quickly and will continue to do so. It has had a quick and very effective start.

With a comprehensive strategy to battle malaria in place, the challenge is now to scale up programs for public health impact. Given the human toll of the disease, which is curable, and in some respects preventable, how to scale up for impact is one of the most pressing Africa policy questions we face.

Collectively, we must gather our will and scale up our programs to stop the spread of this deadly disease. And with so many partners, the coordination of our efforts becomes more critical.

This is true among the U.S. agencies, as it is among international partners, including the new Global Fund. Coordination efforts must occur at the country level and must be led by countries. These actors are fulfilling unique roles only they can perform, due to their expertise and responsibilities.

I am grateful to this group of panelists that we have here with us this morning for our first session. They are a very distinguished group indeed.

I want to say just a word at the very outset about each one, and then very quickly they will be introduced in turn to have short interventions.

The Right Reverend Dinis Sengulane, Bishop of Lebombo, of the Anglican Church of Mozambique. I want to say a few words about the Bishop. Bishop Sengulane is Chair of the Rollback Malaria Board and Cochair of the Inter-religious Campaign Against Malaria in Mozambique. He completed theological training at Salisbury Theological College in England. He has been Bishop of Lebombo since 1976.

His Excellency Minister Aguinaldo Jaime has spent his career promoting foreign investment and free market economic reform in Angola. He is the former Chairman of the Foreign Investment Office, the President of the African Investment Bank, the first private owned bank in Angola.

Mr. William Fleming, a Program Specialist with Christian Children's Fund, a faith-based organization that works in 33 countries to help children and their families. Mr. Fleming spent several years in Africa supporting community health programs.

And, finally, Dr. Stephen Blount is the Director of the Coordinating Office of Global Health with the Centers for Disease Control and Prevention in Atlanta. Dr. Blount led the development and the implementation of the CDC's Global Health Strategy and he is responsible for CDC's Global Health portfolio and has an annual budget of $900 million.

Now, let me tell you at the outset this is a short session. The schedule is extremely tight. When I get the word that the First Lady has arrived with Ambassador Tobias, I don't have any choice.

We close quickly, introduce the choir, people come up. That will be it for this session.

What we need to understand is – the panelists understand this. If you think they are not going on and on, there is a reason for their not going on and on.

What I am going to do, I am going to turn to the panelists and give them a five-minute opportunity to address a very important question. Just give us a quick sense of what the key challenges are in the areas in which they work.

We are going to go through one round that way, and if all goes well, we will do one more quick question for each of them.

I would like to begin with Bishop Sengulane, and ask him to explain some of the challenges that are being faced in Mozambique to reach the most vulnerable with effective malaria prevention and treatment.

Mr. Bishop?

BISHOP SENGULANE: Thank you very much. Good morning. Bom dia, (inaudible). I go straight to the challenges we are facing in Mozambique. Challenge number one is the fact that malaria is the number one killer. At this moment, as we speak, someone is dying of malaria. Malaria is endemic in time and space in Mozambique. The whole country is affected and for the whole year. Mosquitoes are busy distributing malaria to people who haven't asked for it.

The message actually comes to us here. Any of us here. If you want to visit Mozambique, you could undoubtedly catch malaria there. So, any request to provide assistance to fight malaria is a warning to protect yourself against malaria, against this disease.

And because poverty is high, and hunger is there affecting so many people, people's natural resistance is reduced. So, in a debilitated body, malaria can be fatal. Sanitation, especially in towns, is poor, and thus creates favorable conditions for the proliferation of mosquitoes. After floods in the year 2000, in rural areas in particular, stagnant waters have remained in more places, making mosquito multiplication even easier.

Of course, we look at the poverty of the country, making it incapable of making a more efficient spraying process. It has to be very selective methodology, which has to be devised according to the resources that are available.

Health centers are very far inbetween, where people could get their treatment. The use o the media to convey the message for people to know steps to take in order to fight malaria, is expensive. And not always they are – the resources available.

Prevention, cure and research are the practical and urgent steps to be taken now, to make sure that malaria becomes something of the past in Mozambique, as indeed it has become something of the past in some other countries.

We know God is not pleased with malaria and has given humans what it takes to eliminate it. For us who worship God to fight malaria is an act of faith, because we know we are doing what pleases God. Therefore, the fact is that mosquitoes were never given a mandate to kill.

(Laughter.)

BISHOP SENGULANE: And yet they have proved to be such monstrous killers. The time to chase them is not tomorrow. Not sometime this afternoon. But yesterday. And the latest is now. The time to chase the mosquitoes that cause malaria is now, now. And the people to do it are ourselves here. God bless you.

(Applause.)

DR. HILL: Thank you, Bishop. Minister Jaime will tell us a little bit about the situation affecting the challenges in Angola.

MR. JAIME: Thank you, Mr. Chairman. Ladies and gentlemen, distinguished panelists. Although I came to Washington to participate in a ministerial meeting, which dealt with AGOA, I am pleased to be here, because this event deals with a critically important area for Africa, that of disease prevention and treatment.

During the rainy season in my country, Angola, mosquitoes and malaria thrive. An average of 70 percent of children with malaria symptoms actually test positive for the disease. But that figure can rise above 80 percent in some hard-hit areas.

Angola is engaged in the process of rebuilding the country, slightly less than twice the size of Texas. Decades of civil war severely damaged the network of roads and bridges and destroyed all infrastructure supporting medical services in the interior.

This is a long term effort, and it will take time to bring the full scale system to acceptable international standards. It means we will be fighting diseases such as malaria, both preventatively, and in treatment, for some time to come.

Malaria is the number one killer of children in Africa, as it has been said already, and it is the leading cause of morbidity and mortality in Angola. In 2004, we experienced 3.2 million cases of malaria, two-thirds of which occurred in children under five years of age. Close to 40,000 of those resulted in death.

In 2004, Angola switched to artemisinin-based combination therapy, ACT, as its first choice treatment. ACT replaced the cheapest monotherapy, (inaudible), which health experts say encounters resistance in at least 50 percent, and possibly as many as 5 percent of malaria cases.

That important decision meant that the Angolan government became eligible for funding from the Geneva-based Global Fund to fight AIDS, tuberculosis and malaria. But even with assistance from the Global Fund, the World Health Organization, and the steadily increased national budget for health care, Angola cannot achieve the goals necessary to stem the surge of malaria.

In July of last year, First Lady Laura Bush traveled to Africa, and in September she joined representatives of three African nations, and the head of the U.S. Agency for International Development in signing an agreement that would increase U.S. funding to reduce the burden of malaria in Africa by $1.1 billion over five years. Some of you may recall even that the event took place on the sidelines of the session of the United Nations General Assembly.

Angola was fortunate to be one of those three countries to benefit from the plan to increase U.S. funding for the fight against malaria in Africa by $1.1 billion over five years. At the time the agreements were signed, the First Lady said, and I quote:

"Partnerships are vital in eradicating malaria. President Bush and the U.S. government are pleased to work with the governments of Angola, Tanzania and Uganda to move forward on the first phase of the anti-malaria initiative. Together we will implement this initiative as quickly as possible, so we can save the most lives. And together we will give people and nations renewed hope for a healthy future."

Little time was wasted in moving into the operational phase of the program. The plan was to treat the homes of approximately 600,000 people in southern Angola prior to the 2006 malaria season scheduled to begin in April and May of this year.

Working with the Angolan Ministry of Health and Christian Children's Fund of Angola, USAID and (inaudible) International, began the spraying program in December 2005.

It is an ambitious undertaking since the project gained access to at least 90 percent in the targeted areas to successfully reduce reported cases of malaria.

Ladies and gentlemen, the spraying project is one component of President Bush's malaria initiative. Another ongoing component in Angola is the distribution of insecticide treated sleeping nets, to reduce exposure to malaria-carrying mosquitoes.

The goal is to reduce malaria related deaths by 50 percent in Sub-Saharan Africa countries by 2010. Angola also hopes to be among the first group of countries on the continent to achieve the (inaudible) prevention targets of 60 percent coverage of the population with preventive measures.

I look forward to hear what the other panelists will be sharing this morning, and I thank you for your attention.

(Applause.)

DR. HILL: For the President's malaria initiative to work, it has to be a lot more than the United States. It has to be a lot more than international organizations as well, and it requires more than just interagency cooperation in the United States. It requires the vigorous involvement of civil society.

And from the standpoint of the nonprofit sector, Mr. William Fleming can address the question for a few moments, how does the nonprofit arena look at the challenges in scaling up to succeed in the malaria prevention project.

MR. FLEMING: Good morning, everyone. It's a real honor to be here and to talk with you today. I'll try and be vigorous and short.

I think that our focus, since our other guests have talked about the general situation. I think I'll focus on our work in emergency settings and some of the barriers that we encounter there.

Our work with emergency situations is ongoing in Chad and Uganda, and has been – and is now in post-conflict in Angola, Liberia and Sierra Leone.

Some of the challenges that we encounter as we implement the interventions that have been mentioned, particularly health education, distribution of nets, community mobilization for spraying, and really helping people understand and access care. Some of those barriers that we encounter – include in the IDP or the refugee camp setting the appropriateness of nets in some of the housing that we have to provide, there is nowhere to hang them, people are constantly moving, so the idea of sleeping under a net when you are moving day to day, is not really something that people can do.

So, we encountered that regularly in Uganda, as you all have probably heard about the movement of populations in Northern Uganda.

There is also, as has been mentioned, the lack of health care facilities, training and capacity in these settings. They have either been destroyed or they were never there. People are not moving into areas where health care is available, obviously, when they are in a conflict setting.

There's also a lack of funding for malaria programming in emergency settings. There's so many needs, so many priorities, and malaria sometimes does not make the list.

However, if you look at Rollback Malaria and some of the information that they have there, they will explain that kind of central role that malaria plays in emergency settings, often leading to more deaths than the conflict itself by disrupting the prevention and care programs that were on the ground. And we certainly have experienced this.

It probably goes without saying, then, that the vector control measures that we can put in place in emergency settings just don't happen. There's a lot of standing water. People are moving into areas where there has been absolutely no vector control, and so the problem is just compounded.

Those are some of the key problems that we experience in emergency settings. As I mentioned, we also work in conflict and post-conflict settings. We also work in a number of countries in Africa and Asia that are affected by malaria, and we do try to support comprehensive programming in all of those.

I'll just mention a few barriers to scale up that I think we can say generally and then I will finish with my comments.

One, I think we have a long way to go toward in really supporting coordination of the programs that are coming into countries now. There's quite a bit – much like tuberculosis and AIDS, there's quite a bit more money now. There's quite – very many actors suddenly. And so we've got to do a lot to invest in coordination and collaboration. Those are somewhat buzz words, but in reality we have to be talking to one another.

And so I think it's important that we continue to have events where we bring all the actors at the country level together to communicate and collaborate.

I think we need to make sure that the interventions that we support are indeed holistic and they involve each of the interventions that we have talked about, so we are not just doing spraying without the health education, without the nets, and without strengthening the health care system.

So I think this initiative is really set down a path that is holistic and supports a wide range of options, but we've got to make sure that we don't pick up one and leave the others behind.

Finally, there is the ever present need for capacity building. This initiative will end one day, and we've got to make sure, of course, that our partners in the field can continue what we have started. It is important that we invest in national programs all the way down to community program. We'll talk about that later if we have time.

Thank you very much. It's a pleasure to be here.

(Applause.)

DR. HILL: Thank you, William. USAID's key partner in a lot of our efforts around the world on many things is the CDC. So, we are particularly honored to have Dr. Stephen Blount to share some thoughts on the challenges of scaling up programs.

DR. BLOUNT: Thank you very much. Good morning. Malaria remains an unacceptable scourge, as all our panelists have mentioned, despite the proven effective interventions.

Key challenges for scaling up. I'll mention just a few. The first – in fact, just a follow-up on the last speaker. Resource capacity in African health care setting is limited. For effective commodity distribution, people must be trained to do it and how to do it well.

The health care system, in order to overcome this challenge, must be able to absorb malaria resources and then translate them into training, supervision, adequate compensation for public health care providers.

A second problem is poor access to health care. For the long term, increased investment is needed to bring public health facilities closer to the populations they serve.

For the short term, a two-pronged approach is needed. The first is to use community health workers to extend the health care system in the community. For example, home based malaria treatment management.

The second is to increase the involvement of the private sector in malaria prevention and treatment. For example, train and accredit private pharmacies and shops where malarial are sold.

Another barrier is insufficient resources in behavior change and communication. Well designed and widespread communication campaigns to educate Africans at risk for malaria must go hand in hand with malaria prevention and treatment programs.

Another barrier – weak commodity procurement and distribution systems. We need to strengthen the ability of countries to better estimate their commodity needs and then efficiently distribute them. This is especially urgent when artemisinin combination therapies have a very short shelf life in pharmacies.

I'll go quickly. There are a number of barriers we are anxious to share as well as some successes with you.

Insufficient resources for operations research. Good ideas need evaluation before they can be brought to scale, and that evaluation requires a commitment to ensuring that strategies are grounded in good science.

And finally, because there are successes, we need better mechanisms to share both what has worked and what has not worked. We need to help African countries and countries across the world confronting malaria to share with each other in real time the lessons learned.

We must foster an environment in which the right people are connected to each other, and to the right ideas, and to the right time, which, as the first speaker said, is now.

(Applause.)

DR. HILL: When the President announced the middle of last year his initiative on malaria, there were a lot of people who wondered how quickly we could get this thing up and going.

And people have been amazed how fast it has happened, and they have asked the question, how in the world have you succeeded in rolling out interventions that have helped so many millions of people already.

I think the speakers this morning, the way they were able to keep to a timetable of five minutes or less, I am almost

right on my number here. It's unbelievable.

This gives us the opportunity to ask them all one more question. And it's an important question, because it has come up several times. We've got to figure out a way not to squander the resources that are before us. And I would like to ask Bishop Dinis here if there are specific things in Mozambique that you could point to as best practices that seem to really be generating unusual response.

BISHOP SENGULANE: Thank you. Of course, as a preacher, I must be a man of good news. I have a good news when we talk about malaria.

Well, whatever I share from Mozambique, I am not a specialist. I am sharing as a beggar, telling other beggars where you can try – where you can continue begging, where you have been begging with some degree of success.

What is more likely to be good news? Well, number one, none of us here want to die of malaria. We are here because we are committed to stop malaria from continuing to kill.

The costs involved to fight malaria are available under the sun. God is a good mathematician, and before creating human beings, He placed under the sun resources to make us have fuller life, including resources to fight malaria and other diseases.

And this is good news. When we spoke some years ago about our commitment to fight malaria through Rollback Malaria, civil society and the people in the institutions of good will adhered to the idea, to the effort.

Some religious bodies in the country have received the generous assistance of groups like Episcopal Relief and Development, Hope Africa and others. The Center for Global Justice and Reconciliation of the Washington National Cathedral and their partners have responded with deep interest and immeasurable zeal to our small initiatives as religious leaders in Mozambique who commit themselves to fighting malaria.

Religious bodies have, at least in the case of Mozambique, more than 4,000 places of worship and of religious formation – hospitals, orphanages, schools and community centers, which can be used as centers to spread the message to fight malaria.

And that is promising. Religious bodies have centers of their activities in cities and rural areas to the most remote areas. A message entrusted to their organizations will reach all corners of the countries and they can be used as reliable channels of resources to fight malaria for a long time. After all, they believe in eternity.

The level of scientific knowledge in various fields within such a short time and considering how long malaria has been with us, make us believe that if we make available more time, more financial resources, and more people who are dedicated to research, we could reach more satisfactory results than we have so far in fighting malaria.

Because a religious bodies are by nature inclined to follow a regular calendar to pursue certain agendas for the well-being of God's people, they can use methodologies that will keep malaria in the agendas of various sectors of society continually.

So far, the most efficient partner to spread the message about malaria have been the media. What a wonderful opportunity to continue spreading this message as media become more and more sophisticated and reach many areas. What will save human lives as malaria gets more support from all of us is – can be done through the media.

And, finally, God is smiling, as He sees us gathered from various quarters of the earth to say that we don't want malaria to continue killing people. We want to cooperate with God when He created the world, and everything was very good.

Thank you.

(Applause.)

DR. HILL: Thank you, Bishop. And now, Minister Jaime regarding Angola and best practices.

MINISTER JAIME: Well, ladies and gentlemen, I am not a specialist in this field. So, what I can tell you is it's really very difficult in a country devastated by civil war. And, as you may remember, Angola has been at war for three decades. During this war, we lost the stock capital of our economy.

So, in such an environment, it is really very difficult to set the priorities right. So, every member of the government, in the beginning of – when we have to allocate scarce resources to competing demands, you know, that's really a very difficult task to accomplish.

And what I can tell you, despite the fact that Angola has been blessed with oil, and is set to be a rich country, to rebuild the basic infrastructure of the country, we would need 60 billion U.S. dollars.

So, can you imagine the huge task that we are facing, when we are confronted with diseases like malaria, HIV/AIDS and other diseases?

So, what we have done in Angola is to allocate resources for the social sectors in the total investment program that we have in our country, we have allocated 23 percent for health, 19 percent for education and 51 percent for what we call community services.

And this is the response that the government had to fight malaria, to control this disease, to have a productive people that can engage in the reconstruction tasks that lie ahead.

So, I would finish by saying, as I have already said, malaria is the main killer in Angola. It has had a devastating impact in our population. Although we are a relatively huge country, we have a small population, and if we fight malaria and other diseases effectively, then we can succeed in our reconstruction process.

Thank you.

(Applause.)

DR. HILL: And now Mr. Fleming will deal with the nonprofit perspective on best practices.

MR. FLEMING: Well, it may not come as a surprise to any of you that my focus at this point will be on getting services down to the community level.

Most of us NGOs or PVOs, as we are often called, really focus services at the community level, and I think that is appropriate.

When you think about the scale of the reconstruction needed in Angola alone, not to mention countries that never even had the infrastructure to lose, there is a lot of work to be done, and I think it is pretty unrealistic in the short or medium term to expect that we will have the health care infrastructure that we need. Would that it were so.

But it likely will not be. But we have had success with very simple, very doable models of health care, particularly malaria prevention and care at the community level.

And I just want to touch on three elements that I think we should be supporting, and are supporting, through the PMI and other efforts.

One, the lowest level of health care facilities, often called the "health hut" or "health post" – and those work. And those are centers around which communities can organize and provide services to their community members.

So I think that we need to invest our time and efforts there. Again, we are trying to reach people early in the malaria cycle, and not have them advance into kind of advanced malaria, so we want to reach them where they live. And I think that's one way we can do it. And we have shown success. And I know many other NGOs have, as well.

We also need to invest, as was mentioned, in those community health care providers that fall outside the traditional trained health care workers, like the traditional birth attendants, who are sometimes trained and sometimes not. Community health volunteers, the health committees that exist, as well as the shop keepers, and other vendors that

play a major role in health care and often aren't engaged.

So I think it's important that we focus on them and really bring them into the circle, and use them as a vehicle for addressing malaria.

And, finally, I think at the community level it is important that we put the client, and in this case I am thinking of the household, at the center of our work and really invest in addressing what they need to adopt the measures that we are trying to sell or to push.

We can distribute nets for the next century. If people don't use those nets, we are not going to get anywhere with malaria. So, it's not as simple – and I know that most of you probably know this – so it's not as simple as handing out the nets, it's more complicated. We have to make people want to use the nets and to understand why they should be used.

So, we can't just focus on commodity distribution, which is easy to count, and easy to report on. We've got to get people to use those commodities, and that's got to be central to our efforts.

I'll finish then, with two recommendations that come out of my work – country offices. One is that the funding for nets in particular is inconsistent, and often we are talking about nets and don't have access to them, or they are there one day and not the next.

So, there is a lot of work to be done to make nets really available for people to use, once we have convinced them to use them.

And the last point that I would like to make is that I think in Africa the last statistic I read is that something like 20 to 25 countries have approved and really integrated combination therapy into their treatment guidelines. But that treatment is not available at the community level where people have malaria. So, it's not as simple as getting the guidelines, or getting people committed to it.

We've got to make sure that drugs get out to where people are. And again, the idea of a health center being reachable for most people – and again I'm focusing on Africa here – for most people, it's not realistic. So, we've got to use those other methods to get them out. They work, and I would be happy to share information with any of you that are interested. They work. And we can rely on communities to take care of themselves, and we should invest there.

Thank you.

(Applause.)

DR. HILL: And, finally, Dr. Blount, from CDC.

DR. BLOUNT: Thank you, again. We've got only two minutes, so I will give two examples. Following a man of God, a man of money, a man in the community, I'll be very brief.

(Laughter.)

DR. BLOUNT: We have seen some remarkable successes that can and should be replicated across the Continent. I'll give two in my short time.

The first is integration of long-lasting insecticide treated nets in combination with immunization campaigns. In Togo, in 2004, during a six-day campaign, free of charge, to 900,000 children, that is, between the ages of nine months and five years of age, almost 96 percent of the population of that age, a measles vaccine was provided, a polio vaccine was provided, treatment for intestinal worms, and an insecticide-treated net.

For every child who came – and sometimes there was more than one child per family, the family received a bed net. Six days, 730,000 households received bed nets. The estimated cost per child for these four interventions was only $6.00 (U.S.). I think our economists here and in the audience would recognize that's an excellent return on

investment.

This successful effort in Togo, which was a pilot effort, demonstrated in the first pairing of immunization effort at the national level with bed net distribution that it could be done successfully. And this has allowed Togo to acahieve rapidly in all of the six regions of its country, very high levels of ITN coverage. ITN coverage in children of this age jumped as a result of that campaign from 8 percent to 62 percent, thus putting Togo in an excellent position to reach and maintain the Abuja targets.

Lessons learned from this effort nationwide, first integrated effort are going to guide similar efforts this year and next across Africa.

The second successful intervention was the delivery of insecticide treated nets through antenatal care clinics, prenatal care clinics in Malawi, an innovative effort to provide nets at highly subsidized price to pregnant women attending prenatal care clinics has resulted in the delivery of more than 100,000 nets per month since the program began.

Malawi is also now one of the few countries that will, it is expected, reach and meet the Abuja targets of having 60 percent of pregnant women sleeping under nets.

Two examples in two minutes of very successful programs that we think are worthy of your support, including the World Bank, whose representative has just joined us.

Thank you.

(Applause.)

DR. HILL: I also want to acknowledge – and I should have, right off the bat – Congressman Smith is here from New Jersey. And he is one of the most passionate defenders of health programs for the United States and globally.

And he always asks questions that are probing about how many people are actually helped, not just what does the narrative look like for the description of the program.

You know, I got to thinking as I was sitting here listening to these presentations. And I have looked at the numbers before. But we've met together here for less than an hour – 45 minutes or so, and it's hard to imagine, but in fact it is the case, that during the short time we have been together, about a hundred children in Africa have died. A hundred families are facing the tragedy of the loss of a little one.

And you know, there's two kinds of tragedies in the world. There are the kind of tragedies that hit when a tsunami hits or sometimes an earthquake, and sometimes there is not very much you can do about it. You just pick up the pieces and you move on.

The thing that is so disheartening and discouraging and tragic and unacceptable about malaria is those hundred children didn't have to die. This is one of those preventable diseases that the world faces. This is what we call in the health world, low-hanging fruit.

My guess is that when the historians write the legacy of the Bush years and they talk about the HIV intervention, they are also going to mention malaria, because that huge scale-up of $1.2 billion in addition to what was already in the works and going on over the next few years, will make a tangible and direct difference in the lives of children, saving their lives, etc.

And I am just so delighted that that's the case.

Listening to what was said here, trying to summarize it in a few minutes, it strikes me that a couple of things in particular came out.

One is, it's nice for the international community and the United States to scale up and put more money into it and make a difference. But malaria is a little different than a lot of other diseases. I mean, guinea worms, we heard a

presentation on at Global Health Council recently. And the Carter Center's response for 99 percent, most of that problem being eliminated. And it's like polio, if you work hard enough, you might eradicate it.

Malaria, most experts say, is going to be around as something you have to deal with for a long time, which means if you can do your interventions in a way that build capacity, and, as the Bishop said, you can access the networks that can really do the communication messages and deliver the services, etc., then you've got something that is sustainable and will make a difference over the long term.

And so the first lesson I think we can take away from what our panelists talked about today was the importance of sustainability of these efforts, community based, as you put it. We have to work on that.

But the second one is the theme that I have heard Paul Wolfowitz talk about before, from the World Bank. And that is, if there isn't cooperation internationally, and within the United States, on these efforts, we simply won't accomplish everything we can accomplish. There's a lot of well meaning people out there. A lot of good programs.

But at the end of the day, and this was, I think, mentioned by one of our speakers as well, with the scale of the money that is going into malaria, you can't just assume that necessarily all that funding is going to necessarily get the kind of result you want. If you don't keep talking, if you don't compare notes, if you don't let somebody know where you are doing what, the chances of duplication and just not getting all of the bang for the buck that you can get, is certainly likely to be the case.

So, I think the message to us when we work with Rollback Malaria, the Global Fund, the interagency process of the United States, CDC, our meetings often include Department of Defense and others who are doing something related to this, that needs to go forward. Because at the end of the day, the old adage indeed is true – that the sum of what is done collectively is greater than the sum of individual programs done without coordination.

And here the difference between what you would accomplish and what you might accomplish is measured in lives, and not just efficiency, so to speak.

That sort of wraps up the conclusion of this panel.